Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ADDISION TX 75001

SURGERY CENTER OF DUNCANVILLE
15305 DALLAS PARKWAY, SUITE 1600 CSO

Respondent Name

DALLAS COUNTY

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-12-0511-01

MFDR Date Received

OCTOBER 17, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was billed requesting payment of the service portion only as a third party vendor was billing for the implant. The claim was processed and an original payment in the amount of $9,966.33 was issued. According to our calculations the MAR for the total amount of the claim is $8,156.77. This would leave an overpayment owed to the carrier of $1,808.56. An overpayment letter was mailed to the carrier. In response we received a request for refund in the amount of $4,218.78. A refund in the amount of $4,218.78 is being processed and will be issued as requested with the next 14-business days. It is our understanding that multiple procedure discounts are not to be taken on device intensive procedures. With the refunded amount of $4,218.78 issued this will leave our payment short of $2,410.22 by our calculations."

Amount in Dispute: $2,410.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the enclosed Trailblazer Ambulatory Surgery Center Manual page 39, it states:

> When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, Medicare will allow 100% of the highest paying surgical procedure…plus allow 50 percent of the applicable payment rate(s) for the other ASC-covered surgical procedures subject to multiple procedure discount that are furnished in the same session.

Per the instructions on the CMS 1500, Surgery Center of Duncanville requested reimbursement for the service portion only as a third party was to bill for implants.

The service portion reimbursement for the device intensive code 63650 is $2,445.76. This was calculated using the Medicare ASC fee value for Dallas county $3,681.50 (reference enclosed Trailblazer ASC fee schedule) minus the Medicare Device fee $2,640.75 which equaled $1,040.75. Then the amount of $1,040.75 was multiplied by 235%, which equals $2,445.76.

The service portion reimbursement for procedure code 63650-59 was calculated the same as above and the correct reimbursement is $2,445.76.

Procedure code 63688 is **not** a device intensive code and is subject to the multiple procedure rules. Reference the enclosed Addendum AA. The ASC Medicare reimbursement for this code is $1,118.99. This amount multiplied by the DWC markup of 235% equals $1,712.05. Dividing this amount by 50% equals the correct reimbursement of $856.03.

The total reimbursement for treatment performed on January 20, 2011 should have been $5,747.55. Deducting this amount from the prior reimbursement amount of $9,966.33 leaves an overpayment of $4,218.78...It is not felt the reimbursement calculation submitted by Surgery Center of Duncanville are accurate. As of October 24, 2011 CCS Holdings had not received the refund amount of $4,218.78."

Responses Submitted by: Argus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2011	ASC Services for CPT Codes 63650, 63650-59, and 63688	$2,410.22	$458.68
TOTAL		$2,410.22	$458.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1T-Workers compensation state fee schedule adjustment * reimbursement per ASC Guidelines Rule 134.402.
   - 59-Processed based on multiple or concurrent procedure rules.
   - W5A-Request or recoupment for an overpayment made to a health care provider. Upon final audit, an overpayment to the provider has been identified. Provider should remit this amount to the carrier as soon as possible.*
   - 193W-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.*

Issues

1. What is the maximum allowable reimbursement (MAR) for 63650 and 63650-59?
2. What is the MAR for code 62688?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(2)(B)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
   (2) Reimbursement for device intensive procedures shall be:
   (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
(ii) the ASC service portion multiplied by 235 percent."

CPT code 63650 is described as "Percutaneous implantation of neurostimulator electrode array, epidural"

Because the requestor asked for separate reimbursement for the implantables, only the service portion is in dispute.

Per ADDENDUM AA, CPT code 63650 is a device intensive procedure and is exempt from the multiple procedure rule discounting.

To determine the MAR for procedure code 63650 is a five step process:

Step 1 gather factors:

Addendum B hospital outpatient prospective payment amount for code 63650 CY 2011 is $4,553.02.

The device dependent APC offset percentage found in the Addendum B for National Hospital OPPS for code 63650 for CY 2011 is 58%.

The Medicare fully implemented ASC reimbursement for code 63650 CY 2011 is $3,707.45.

The CMS City Wage Index for Dallas County is $0.9860.

Step 2 determine the device portion:

$4,553.02 multiplied by 58% = $2,640.75.

Step 3 determine the geographically adjusted Medicare ASC reimbursement for code 63650:

The Medicare fully implemented ASC reimbursement rate is divided by 2 = $1,853.72 ($3,707.45/2)

This number X City Wage Index is $1,853.72 X 0.9860 = $1,827.76.

Add these two together $1,853.72 + $1,827.76 = $3,681.48.

Step 4 determine the service portion:

Subtract the device potion from the geographically adjusted Medicare ASC reimbursement

$3,681.48 minus $2,640.75 = $1,040.73.

Step 5 multiply the service portion by the DWC payment adjustment factor of 235%

$1,040.73 multiplied by 235% = $2,445.71

Code 63650 is not subject to multiple procedure discounting; therefore, the MAR for the service portion is $2,445.71.

The requestor billed for 2 units; therefore, $2,445.71 X 2 = $4,891.42.

2. CPT code 63688 is defined as "Revision or removal of implanted spinal neurostimulator pulse generator or receiver."

Per ADDENDUM AA, CPT code 63688 is a non-device intensive procedure and is subject to multiple procedure rule discounting.

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

The MAR for CPT code 63688 in Dallas County is $2,629.62 ($1,118.99 X 235%). This code is subject to multiple procedure discounting; therefore, $2,629.62 X 50% = $1,314.81.

The total allowable for the disputed services is $6,206.23 ($4,891.42 + $1,314.81). The total amount paid is $5,747.55 ($9,966.33 minus a refund of $4,218.78). As a result, additional reimbursement can be recommended OF $458.68.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $458.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $458.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/02/2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.